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MEDICARE PHYSICIAN GROUP PRACTICE DEMONSTRATION

Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay for Performance Demonstration

Efforts to incorporate value based purchasing strategies into Medicare have large and growing support. The Institute of Medicine has issued reports urging Medicare to reward provider performance; the Medicare Payment Advisory Commission has identified performance-based approaches to achieve improved quality and efficiency; and the health care community has provided leadership for changing how Medicare pays. The Administration and Congress are advancing this concept and today, Medicare is moving to become a more proactive and value based purchaser of health care.

The Physician Group Practice (PGP) Demonstration is the first pay-for-performance initiative for physicians under the Medicare program. The demonstration creates incentives for physician groups to coordinate the overall care delivered to Medicare patients, rewards them for improving the quality and cost efficiency of health care services, and creates a framework to collaborate with providers to the advantage of Medicare beneficiaries. Mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the goals of the demonstration are to:

- Encourage coordination of Part A and Part B services;
- Promote cost efficiency and effectiveness through investment in care management programs, process redesign, and tools for physicians and their clinical care teams; and
- Reward physicians for improving health outcomes.

Under the three year demonstration, which was extended for a fourth year, the Centers for Medicare & Medicaid Services (CMS) rewards physician groups for improving patient outcomes by proactively coordinating their patients' total health care needs, especially for beneficiaries with chronic illness, multiple co-morbidities and those near the end of life. Since they will share in any financial savings that result from improving the quality and cost efficiency of care, the groups have incentives to use new care management strategies and electronic tools that, based on clinical evidence and patient data, improve patient outcomes and lower total medical costs. These strategies are designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations, and improve quality of care.

Demonstration Overview

Under the demonstration, physician groups continue to be paid under regular Medicare fee schedules and may share in savings from enhancements in patient care management. Physician groups may earn performance payments of up to 80% of the savings they generate. The Medicare Trust Funds retain at least 20% of the savings. Performance payments are divided between cost efficiency for generating savings and performance on 32 quality measures phased in during the demonstration. As quality measures are added in performance years two and three, the quality portion is increased so that by the third performance year 50% of any performance payment is for cost efficiency and 50% is for achieving national benchmarks or improvement targets on quality.

At the end of each performance year, total Medicare Part A and Part B per capita spending is calculated for assigned beneficiaries and compared to a base year period to calculate an assigned beneficiary growth rate. Physician group practices whose Medicare spending growth rate for assigned beneficiaries is more than 2 percentage points lower than their comparison population may share up to 80% of Medicare savings. The comparison population is derived from each physician group's local market area. Total Medicare Part A and Part B per capita spending is calculated for Medicare beneficiaries residing in the local market area who did not have an office visit at the physician group during the performance year and compared to a base year period to calculate the local market area growth rate.

Medicare beneficiaries are assigned to each group if the group provided the plurality of their office or other outpatient evaluation & management services during the performance year. On average, assigned beneficiaries have 5 visits at the physician group during the year.

Expenditures are risk adjusted, since the growth in per beneficiary spending can be affected by changes in case-mix, or the health status, of the beneficiaries in a group. The demonstration uses the CMS-HCC concurrent risk adjustment model which uses current year diagnoses to adjust current year expenditures. Using concurrent risk adjustment in the demonstration provides an accurate assessment of changes in the health status of beneficiaries.

Measuring Quality

Effective pay-for-performance systems require effective measures of performance as their foundation. The ambulatory care measures used under the demonstration are part of Medicare's comprehensive efforts to improve the quality of care delivered to Medicare beneficiaries. The measures were developed by CMS working in an extensive process with the American Medical Association's Physician Consortium for Performance Improvement and the National Committee for Quality Assurance (NCQA). The measures have undergone review or validation by the National Quality Forum, which provides endorsement of consensus-based national standards for measurement and public reporting of healthcare performance data.

CMS worked with the physician groups to develop a consensus agreement on how to report the measures and how to use them to assess performance and reward quality under the demonstration. The measures are phased in starting with the diabetes mellitus measures that

were used to assess performance and reward quality care during the first performance year. Additional measures focusing on congestive heart failure and coronary artery disease were added in performance year two. Hypertension and cancer screening measures were added for performance years three and four.

The demonstration rewards groups that improve and deliver high quality care. National benchmarks and group specific quality improvement targets are used to provide incentives for quality improvement as well as to recognize groups that are achieving high levels of performance. Combining national benchmarks and quality improvement targets provide for achievable benchmarks for care.

Physician Group Practice Demonstration Quality Measures			
Diabetes Mellitus	**Congestive Heart Failure**	**Coronary Artery Disease**	**Preventive Care**
HbA1c Management	Left Ventricular Function Assessment	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	Left Ventricular Ejection Fraction Testing	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	Weight Measurement	Beta-Blocker Therapy – Prior MI	Blood Pressure Control Plan of Care
Lipid Measurement	Blood Pressure Screening	Blood Pressure	Breast Cancer Screening
LDL Cholesterol Level	Patient Education	Lipid Profile	Colorectal Cancer Screening
Urine Protein Testing	Beta-Blocker Therapy	LDL Cholesterol Level	
Eye Exam	Ace Inhibitor Therapy	Ace Inhibitor Therapy	
Foot Exam	Warfarin Therapy for Patients HF		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

Physician Group Practices

CMS selected ten physician groups on a competitive basis to participate in the demonstration. The groups were selected based on technical review panel findings, organizational structure, operational feasibility, geographic location, and demonstration implementation strategy. Multi-specialty physician groups with well-developed clinical and management information systems were encouraged to apply since they were likely to have the ability to put in place the infrastructure necessary to be successful under the demonstration.

The demonstration allows CMS to test new incentives in diverse clinical and organizational environments including freestanding multi-specialty physician group practices, faculty group practices, physician groups that are part of integrated health care systems, and physician network organizations. The demonstration has fostered a nation-wide learning collaborative among the groups who voluntarily participate in this demonstration as a result of their leadership in their communities and profession. CMS is working with the groups to identify successful health care redesign and care management models developed for the demonstration that can be replicated and spread across the health care system.

The ten physician groups represent 5,000 physicians and 224,000 Medicare fee-for-service beneficiaries. The physician groups participating in the demonstration are:

Billings Clinic, Billings, Montana
Dartmouth-Hitchcock Clinic, Bedford, New Hampshire

The Everett Clinic, Everett, Washington
Geisinger Health System, Danville, Pennsylvania
Middlesex Health System, Middletown, Connecticut
Marshfield Clinic, Marshfield, Wisconsin
Forsyth Medical Group, Winston-Salem, North Carolina
Park Nicollet Health Services, St. Louis Park, Minnesota
St. John's Health System, Springfield, Missouri
University of Michigan Faculty Group Practice, Ann Arbor, Michigan

Performance Year 2 Results

At the end of the second performance year, all 10 of the participating physician groups continued to improve the quality of care for chronically ill patients by achieving benchmark or target performance on at least 25 out of 27 quality markers for patients with diabetes, coronary artery disease and congestive heart failure.

Five of the physician groups -- Forsyth Medical Group, Geisinger Clinic, Marshfield Clinic, St. John's Health System, and the University of Michigan Faculty Group Practice -- achieved benchmark quality performance on all 27 quality measures. This compares to two physician groups that achieved benchmark performance on 10 diabetes mellitus measures that were the focus of performance year 1.

These groups achieved outstanding levels of performance by having clinical champions (physicians or nurses who are in charge of quality reporting) at the practice, redesigning clinical care processes, and investing in health information technology. The enhancements to their electronic health records and patient registries allow practices to more easily identify gaps in care, alert physicians to these gaps during patient visits, and provide interim feedback on performance.

The groups demonstrated improved quality of care delivered to Medicare beneficiaries on the chronic conditions measured by increasing their scores on at least 19 of the 27 measures. Furthermore, physician groups increased their quality scores an average of 9 percentage points across the diabetes mellitus measures, 11 percentage points across the heart failure measures, and 5 percentage points across the coronary artery disease measures.

Given their extensive focus on quality under the demonstration, the physician groups agreed to place their incentive payments under CMS's Physician Quality Reporting Initiative (PQRI), a pay for reporting initiative, at risk for performance on the 27 quality measures reported under the demonstration. As a result, all physician groups received at least 96 percent of their PQRI incentive payments, with five groups earning 100 percent of their incentive payments. The 10 physician groups earned PQRI incentive payments totaling $2.9 million.

In addition to achieving benchmark performance for quality, several physician groups experienced favorable financial performance under the demonstration's performance payment methodology. For patients with diabetes or coronary artery disease, Medicare

expenditures grew more slowly for beneficiaries assigned to the physician groups than for beneficiaries in the comparison group with the same conditions.

This lower expenditure growth for patients with chronic conditions as well as complex patients treated in the ambulatory and hospital settings contributed to four physician groups sharing in savings for improving the overall efficiency of care they furnish their patients. The four physician groups – Dartmouth-Hitchcock Clinic, The Everett Clinic, Marshfield Clinic, and the University of Michigan Faculty Group Practice – earned $13.8 million in performance payments for improving the quality and cost efficiency of care as their share of a total of $17.4 million in Medicare savings. Additional physician groups had lower growth in expenditures than their local market area, but not sufficiently lower to share in savings under the demonstration's performance payment methodology.

In total, the 10 physician groups earned performance payments for improving the quality and efficiency of care totaling $16.7 million in the second performance year.

Care Management Strategies

One of the unique features of this demonstration is that physician groups have the flexibility to redesign care processes, invest in care management initiatives, and target patient populations that can benefit from more effective and efficient delivery of care. This helps Medicare beneficiaries maintain their health and avoid further illness and admissions to the hospital. The following provides an overview of the quality and efficiency innovations underway at each demonstration site.

Billings Clinic improves the care of patients with diabetes through the use of a diabetes patient registry, electronic medical record modules that provide for consistent evidence-based care, and an expanded team of diabetes experts/educators offering a patient friendly report card to help patient's understand their disease and raise provider accountability for health maintenance. In addition, a pharmacy driven insulin protocol for glycemic control in the inpatient setting strives to decrease length of stays and reduce complications and potential readmissions. As a result, a majority of the clinic's eligible physicians have been recognized through NCQA's Diabetes Physician Recognition Program for excellence in diabetes care. The clinic also continues efforts to: (1) redesign heart failure care by leveraging an RN-directed telephonic computerized patient monitoring system to support quality of life and decrease 'all cause' admissions; (2) decrease medication errors that lead to illness and hospitalization by using electronic prescribing of medications and reconcile medications at every care opportunity; (3) expand the palliative care team to reach clients prior to an admission via outpatient appointments, extended care facilities, and during ER visits; and (4) develop a community crisis center to provide an evidence-based integrated crisis model to benefit dual eligible patients with mental health related events. For more information, contact: F. Douglas Carr, M.D. at dcarr@billingsclinic.org.

Dartmouth-Hitchcock Clinic focuses on improving quality while reducing costs through implementation of evidence-based care initiatives. The clinic uses recognized experts to educate physicians and support staff in understanding evidence-based care guidelines. Electronic tools and reports including disease registries, dashboard reports to track progress on quality measures,

and electronic medical record enhancements are used by the physicians and staff at the point of patient contact to identify patients with chronic disease and care gaps. Evidence-based care implementation also requires changing workflow processes and roles for support staff. For example, in the primary care departments, nurses target interventions to high-risk patients using motivational education on disease and personal health care through in-office visits and/or post hospital discharge phone calls. For more information, contact: Barbara Walters, D.O. at Barbara.A.Walters@Hitchcock.org.

The Everett Clinic is improving health care delivery to seniors by: (1) providing electronic patient reports to primary care physicians to use in addressing issues with diabetes, heart disease, hypertension, and mammogram and colonoscopy screening results; (2) coaching hospitalized patients and caretakers to guide them thorough complicated care processes during hospital stays and upon discharge; (3) having physicians follow-up with patients within ten days of hospital discharge to address any unsolved or new health problems; and (4) partnering with local providers to deploy new palliative care programs in physicians' offices to improve end-of-life care for approximately 600 patients. For more information, contact: James Lee, M.D. at Jlee@everettclinic.com.

Forsyth Medical Group continues to build on its successful implementation of a chronic care model for care delivery at the practice level. Patient care is supported through engaged patient care staff at the practice level focusing on continued education and development of competencies related to the identified indicators. Recognizing that knowledgeable staff supporting physicians are an important element to offer all patients a remarkable experience, the physician steering committee was expanded to include providers from more diverse practices. Physician champions promote programs targeted to improve quality measures and patient outcomes. Educational materials continue to reach a broad range of patients with chronic disease and the scope of education was broadened to include end of life care, fall risk assessment and prevention and medication reconciliation and safety. The COMPASS Disease Management Program grew in both services offered to patients and contacts by nurse disease managers with a continued emphasis on congestive heart failure and chronic pulmonary disease. For more information, contact: Nan Holland, R.N. at nlholland@novanthealth.org.

Geisinger Clinic focuses on: (1) using its electronic health record to identify and systematically resolve deficiencies in care for beneficiaries with diabetes, coronary artery disease, chronic kidney disease, hypertension and hyperlipidemia; 2) automating telephonic remote monitoring and order execution for beneficiaries with congestive heart failure; 3) automating identification, notification and scheduling of pneumococcal and influenza immunization services; and 4) high-risk case management for beneficiaries who receive care at any of the Geisinger Medical Home pilot sites. For more information, contact: Mark Selna, M.D. at MJSELNA@geisinger.edu.

Marshfield Clinic is participating in the demonstration as a reflection of its mission to serve patients through accessible, high quality health care, research and education. The clinic expanded a number of on-going successful initiatives and accelerated the development and adoption of others including enhancements to its electronic health record to systematically expand a support structure to implement care management and coordination. Specifically, the clinic expanded its anticoagulation care management program across the entire system and

developed a heart failure care management program with the goal of improving clinical care, improving quality of life and decreasing costs and hospitalizations. In addition, the clinic continues to promote use of its nurse advice line, develop clinical practice guidelines and monitor population-based clinical performance through clinical storyboards. For more information, contact: Theodore A. Praxel, M.D. at praxel.theodore@marshfieldclinic.org.

Middlesex Health System is participating in the project as a network of physicians affiliated with a community hospital, rather than a multi-specialty group practice. Interventions focus on processes to improve and demonstrate quality and safety across the continuum of care, building on a long history of close collaboration between the hospital and its medical staff and a commitment to the mission of community health improvement. Specific programs include enhanced patient education and care management in heart failure, diabetes, immunizations, medication safety, palliative care, and use of tele-monitoring technology in the home. For more information, contact: Arthur McDowell, M.D. at Arthur_McDowell_MD@midhosp.org.

Park Nicollet Health Services started an inpatient palliative care program and continue to enhance their care of patients with diabetes and heart failure. An innovative telephone monitoring program was instituted for high-risk heart failure patients. Currently, over 560 patients with heart failure have been enrolled into an automated telephonic program to improve their quality of life. Each patient makes a daily call with weight and symptom reports, allowing nurse case managers at the clinic to spot early signs of deterioration and intervene in their heart failure management. Electronic patient registries are the cornerstone of management for patients with chronic disease and have been combined with the clinic's existing electronic medical record. As a result, patient information can be reviewed by the physician care team for unmet health care needs prior to upcoming appointments. Another improvement was initiating same-day lab testing prior to the visit for many of these chronic disease patients. Using these steps to reduce lead time, they have significantly increased time for important face-to-face interaction when crucial decisions need to be made about treatment. For more information, contact: Mark Skubic at Mark.Skubic@ParkNicollet.com.

St. John's Health System developed a comprehensive patient registry to respond to the demonstration's quality improvement incentives. The registry is designed to track patient information, identify gaps in care, and ensure that appropriate and timely care is provided. A key element of the patient registry is the visit planner which is designed to complement physicians' established clinical work-flow process. It provides a "to do" list for physicians prior to each patient visit, with reminders for needed tests or interventions. The visit planner consists of a one-page summary for each patient showing key demographic and clinical data, including test dates and results. An exception list highlights tests or interventions for which the patient is due and provides physicians with reports on areas where patient care can be improved. Patients can be called or letters sent indicating the need for a visit or test. The provider/clinic manger uses the decentralized reporting feature to generate un-blinded outcome reports from the registry at both the individual provider and clinic levels. Physicians have responded positively to these initiatives, indicating that the quality of care for their patients has improved. In addition, a case manager was deployed in the emergency department to collaborate with the health system and community services to provide transition planning. A heart failure team has been designated to drive the coordination of heart failure care, provider education, and increase outcome success.

Special groups are being convened to focus on diabetic retinal eye exams, mammography and colorectal cancer screenings. For more information, contact: James T. Rogers, M.D. at James.Rogers@Mercy.net or Donna Smith at Donna.Smith@Mercy.net.

University of Michigan Faculty Group Practice focus on improving transitional care and complex care coordination for Medicare patients. The group's transitional care call-back program contacts Medicare patients discharged from the emergency department and acute care hospital to address gaps in care during the transition between care settings. This program also provides short-term care coordination with linkages to visiting nurse and community services and coordination with primary care and specialty clinics. The group also developed a complex care coordination program with social workers and nurses who work with physicians to assist patients who have multiple risks, high costs and complex health status. In the hospital setting, the group developed a pharmacy facilitated discharge program for patients with high-risk medications and a palliative care consult service to work with patients and families to ease end of life transitions. In the second year of the project, these services were joined by a sub-acute service that brings geriatric faculty into local sub-acute facilities and an expanded geriatric inpatient consult service that provides expertise in geriatric medicine and transitional care. The group also has a heart failure nurse tele-management program that coordinates with its heart failure clinics. The group's quality program uses patient registries with relevant quality indicators and individual physician/provider feedback on the quality of care for their patients. For more information, contact: Caroline S. Blaum, M.D. at cblaum@umich.edu.

For More Information

The demonstration started April 1, 2005 and is currently in its fourth performance year. The demonstration is scheduled to end March 31, 2009. For additional information, visit the Physician Group Practice webpage at:

http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage

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